ihs
INTEGRATED HEALTH SERVICES

Certified 7000 1530 0005 5531 5477

February 4, 2002

Ms. Kathleen Hodson
2201 Keystone Drive
Erie, PA 16509

Ms. Hodson:

On Thursday, January 31, 2002 you presented to Sheila Rist in Human Resources, a paper signed by Chiropracter, Dr. Ang. This paper states that you will be excused from work from January 31 through February 28, 2002, when you will be re-evaluated by Dr. Ang.

We spoke with Lisa Williams of the worker's comp insurance carrier, and we are notifying you that you need to see Dr. John Euliano of Orthopedic & Sports Medicine of Erie at phone number 814-454-8287, He is the treating orthopaedic that the insurance company recognizes to relieve you of work duties.

At this present time you are on an unpaid family leave of absence, effective January 31, 2002. While on this leave you will be responsible for paying your employee benefits. On pay end February 6, 2002 your premiums will be deducted from the pay check dated February 15. However, you will be responsible for pay end February 20 and March 6, if you are still out.

Your deductions are as follows:

DMO Dental	$6.43	PPO High Option	$49.00
Employee Life Ins	$5.36	Short Term Disability	$12.80
Long Term Disability	$2.31		

Your payment/check will be made out to Integrated Health Services and you will receive a receipt stating total dollar amount and what paid period you are covering.

Sincerely,

Carl Kovski
NHA

CC: Dr. Euliano
Orthopaedic & Sports Medicine of Erie

INTEGRATED HEALTH SERVICES

February 19, 2002

Certified 7000 1530 5531 5491

Ms. Kathy Hodson
2201 Keystone Drive
Erie, PA 16509

Ms. Hodson:

You will be receiving in the mail from Crawford, Slevin & Hicks your short term disability papers. When you receive these papers there will be forms for you to fill out and for your physician to fill out. The employer will also have forms to fill out. Please return all completed forms to IHS Human Resources to be overnighted to Crawford, Slevin & Hicks. (Do not let your physician mail them; this delays the process.) Crawford, Slevin & Hicks will then review all forms to ensure everything is filled out.

At this time the facility still has light duty work available within your 20lb. max of weight lifting. Enclosed is a copy of your light duty job description, as well as the copy you gave us of functional capacity evaluation signed and dated December 18, 2001. These light duty jobs are well within the functional capacity range. Please review these with your physician. If there is something that your physician feels you should not do please have your physician specify.

Please contact the Administrator, Carl Kovski, by February 27, 2001 to set up a time to verify your return to work date, and to go over the light duty job description.

Carl Kovski, NHA
Administrator

CC: Evan J. Jenkins, Esquire
Lisa Williams of ESIS

Enclosure

SUMMARY PAGE

Patient name : Kathleen Hodson — Eval date: 12-18-01

Referral source: Dr. M. Ang — Dx: Lumbar Disc HNP

LIFTING TOLERENCES:	Occasional	Frequent
Floor to Knuckle:	*20#*	*10#*
Knuckle to Shoulder:	*10#*	*did not demonstrate*
Carry:	*17#*	*did not demonstrate*

POSITIONAL TOLERENCES:	Occasional (0-33%)	Frequent (34-66%)	Constant (67-100%)
Sit:		X	
Stand:		X	
Walk:	X		
Squat:	X		
Kneel:	unable		
Climb Stairs:		X	
Reach Forward:		X	
Reach Overhead:		X	
Use Foot Pedals:		X	
Grip Firmly:		X	
Fine Manipulation:		X	
Static Head:		X	
Trunk Bend:	X		
( ):			
( ):			

RESULT: The client demonstrated the ability to work in the LIGHT classification category for an 8 hour day. (According to the US Department of Labor Standards.)

Signed: Evaluator : DEutmyer,PT Date: 12-18-01

PHYSICIAN : *(I concur with the above, with changes as indicated)*

Physician signature here : _____ *Date:* _____

- **CHECK IN WITH THE SUPERVISOR UPON ARRIVAL FOR ASSIGNMENTS**

***LIST ALL DUTIES THAT ARE COMPLETED DURING THE SHIFT AND GIVE TO THE SUPERVISOR BEFORE LEAVING**

-MA-51 FROM BUSINESS OFFICE

-IDDS COMPLETION

-THIN CHARTS (GET DIRECTION FROM C. COVERDALE AND ALL CHARTS NEED THINNED

-DINING ROOM - MONITOR AND FEED AT ALL MEALS DURING YOUR SHIFT-WEEKDAYS AND WEEKENDS

-NURSING ASSESSMENTS

-WARD CLERK DUTIES ON WEEKENDS AND WARD CLERKS DAYS OFF

-CHECK ALL DOOR NAME PLATES FOR ACCURACY AND REPLACE

-CHECK ALL RESIDENT NAME BANDS AND REPLACE

-SCHEDULING- CHECK WITH CAROL OTIS

-OTHER DUTIES AS ASSIGNED

-COPYING

SCHEDULED WORK HOURS WILL BE 7:00AM to 3:30PM.

1/AMB

Lt. Doty

7/CN

IHS 260

BAYSIDE SCHEDULE.

	MAR		S	M APR		W	Th	Fr	Sa	Su	M	Tu	W	Th	Fri	Sat	S	M	Tu	W	
	29	30	31	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	
Hodson	7	7	7	—	—	7	—	7	3	—	3	3	/	/	3	/	/	3	3	3	/

Kathy,

We can start you on days for a week to get back in the swing of things. Remember your 20# restriction. No lifting. Have CNAs/other nurse help. Have CNA/supervisor's/nurses push your carts 1/2 down the hall. No repositioning or turning residents

RETURN TO WORK RECOMMENDATIONS

ERIE CHIROPRACTIC
Dr. Michael Ang, D.C.
2554 W. 26th St.
Erie, PA 16506
(814) 838-4444

Patient Kathleen Hodson Date 1 / 31 / 2002

Company IHS of Erie at Bayside ✓ Date of Injury 3 / 30 / 2001
___ Work Related ___ Not Work Related

I saw/treated this patient and:

✓ Patient is unable to work at this time and will be reevaluated on 2 / 28 / 2002

_____ Patient is able to work with no limitations or restrictions on _____ / _____ / _____

_____ Patient is able to work with the following restrictions:

PATIENT IS TO OBSERVE THE FOLLOWING LIMITATIONS:

_____ Lifting with a limit of: ____ none ____ 0 - 10 lbs ____ 10 - 20 lbs ____ 20 - 50 lbs ____ 50 - 70 lbs ____ 70 lbs & over

_____ Standing/Walking with a daily limit of: ____ none ____ 1 - 2 hours ____ 3 - 4 hours ____ 4 - 6 hours ____ 6 - 8 hours

_____ Sitting with a daily limit of: ____ none ____ 1 - 2 hours ____ 3 - 4 hours ____ 4 - 6 hours ____ 6 - 8 hours

_____ Driving with a daily limit of: ____ none ____ 1 - 2 hours ____ 3 - 4 hours ____ 4 - 6 hours ____ 6 - 8 hours

_____ Repetitive hand motions to be avoided:
____ Grasping ____ Fine Manipulation ____ Pushing and Pulling ____ Rotation ____ Right
____ Grasping ____ Fine Manipulation ____ Pushing and Pulling ____ Rotation ____ Left

_____ Repetitive motions to be avoided:
____ Bending ____ Squatting ____ Climbing ____ Overhead reaching ____ Twisting
____ Carrying ____ Stooping ____ Pushing ____ Pulling ____ Kneeling

Other Restrictions: _____

Increased back pain

THESE RESTRICTIONS ARE IN EFFECT UNTIL 2 / 28 / 2002 OR UNTIL PATIENT IS REEVALUATED.

Michael K. Ang DC, ABDA
Doctor's Signature

1 / 31 / 2002
Date

DEA # _____

MARY ANN ANDRIOLE-WENDEL, D.O.
ANNE-MARIE LISZKA, D.O.
306 WEST 11TH STREET
ERIE, PA 16501
814-456-8105
PA LIC No. OS-007550-L PA LIC No. OS-006569-L

NAME Kathleen Hodson

ADDRESS _____ DATE 2/14/02

℞ (Please Print)

excuse pt from work

2/14, 2/15, 2/16, 2/17

due to back strain

REFILL _____ TIMES PRN NR

SUBSTITUTION PERMISSIBLE _____ D.O.

IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED, THE PRESCRIBER MUST HANDWRITE BRAND NECESSARY OR BRAND MEDICALLY NECESSARY IN THE SPACE BELOW.

04-SEP-01

TRI01C004_100173494-1_01_25923_0010

WORKER'S C

THIS FORM IS TO BE FILED WITH THE EMPLOYER OR INSURER ACCORDING TO INSTRUCTIONS PROVIDED ON THIS FORM.

Name of Employee KATHLEEN HODSON.

Name of Employer IHS AT BAYSIDE

Name of Insurer IHS OF ERIE AT BAYSIDE

Claim Number (if known) C395C5257989 Date of Birth 11/26/46

Employee SS# 200-34-7211 Date of Injury 3/30/01

Date of Report 3/5/02.

Provider Name ORTHOPAEDIC & SPORTS MEDICINE

03/05/02	KATHLEEN HODSON	
DATE	NAME	REFERRING PHYSICIAN

The patient apparently has not returned to work because of her severe pain and her family physician kept her off work for some period of time. She states that the pain is worsening. It is in her back and now it is going to her left leg as well. She has been taking muscle relaxants and Darvocet. She tells me that she just knows she is not capable of working. She did see Dr. Falasca for initial evaluation and injections are going to be carried out on March 14th. At her request, I have given her a slip that she can be off work for two weeks to facilitate the injections. I gave her a prescription for Darvocet N 100, 30 with two refills. I gave her the benefit of the doubt, however, I think that her complaints are out of proportion to the MRI findings that we have been able to ascertain up until this point in time.

John J. Euliano, Jr., M.D./cao

ORTHOPAEDIC & SPORTS MEDICINE OF ERIE, P.C.
300 STATE ST. • SUITE 400 A • ERIE, PA 16507
PHONE (814) 454-8287 • FAX (814) 454-8470

Providers may not charge for documentation supporting a claim for payment. Providers may charge their usual fee for special reports specifically requested by the Employer/Insurer. All patient information shall be submitted with the knowledge of the patient and must be maintained as confidential by the Employer/Insurer. The insurance plan or program shall not be liable to pay for treatment until the report/claim form has been filed.

Listed on the reverse are guidelines for the completion of billing forms and submission of records

BY MR. LEVINE:

Q With regard to the document here, do you know whether or not Kathy received it?

A I handed it to her personally and discussed it with her.

Q Okay. And is this a schedule?

A Yes, this would be the days she's worked. She come in at 7:00 on these days or at 3:00 on these days.

Q This would have been for March?

A Starts March 29th.

Q Okay. The only other thing I wanted to check with you is would you agree with me prior to the last day that Ms. Hodson was at IHS, she had never been reprimanded for leaving work early?

A I couldn't speak for that during the time period that I was director of nursing.

Q So during the time period you were director of nursing, there were no problems like that?

A For leaving early?

Q Yes.

A Not that I know of.

Q There were no problems where you felt you had to reprimand her for declining work?

A For declining work, not that I know of, no.

MR. LEVINE: I have nothing further at this time.

THE JUDGE: Mr. Miller?

MR. MILLER: Nothing further, your Honor.

THE JUDGE: Okay, fine. You can step down. Thank you.

MR. LEVINE: Just some testimony of the claimant, your Honor.

THE JUDGE: Okay, fine. Would you retake the stand here, please, and you're still under oath.

THE CLAIMANT: Okay.

20130 A MON CINDY BURGER

Business Unit: 20130

Termination Form

Name: Hodson (Last) Kathleen (First) ___ (MI) Social Security: 200 34 - 7211

Personal Data

Please list address employee wants final paycheck sent if different from current address.

Address: _____

City: _____ State: ____ Zip: _____ Phone #: (___) ____ - _____

Job Data

Effective Date: 05 / 20 / 02 Last Day Worked: 05 / 17 / 02

Action: Per Brodsett & Corp Legal

- [x] Termination
  - [ ] Attendance
  - [ ] Death
  - [ ] Dissatisfaction
  - [x] Job Abandonment — Refused to do Hair Assignment
  - [ ] Elimination of Position
  - [ ] License expired
  - [ ] Gross Misconduct
  - [ ] Mutual consent
  - [ ] Layoff
  - [ ] Unsatis. Perform.
  - [ ] Failure to return from leave
  - [ ] Resignation
  - [ ] Transfer to Affiliate
- [ ] Retirement

Is there any continuance of benefits or compensation after termination? [ ] Yes If yes, please attach proper documentation [ ] No

Comments: _____

Signatures:

Manager: _____ Date: _____ H/R: [signature] Date: 4-24-03

Administrator: [signature] Date: 4-24-03 Budget: _____ Date: _____

Next Level Mgr: _____ Date: _____

IHS 275

Entity # 0130 **Data Change Form** Cynthia 0130Zl. A-Mon

Name: Hodson (Last) Kathleen (First) ___ (MI) Social Security: 200 34-7211

Please complete only the items which are changing.

Personal Data

Address: _____

City: _____ State: ____ Zip: _____ Phone #: (___) ___-____

Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

Citizenship: ☐ Native ☐ Alien Permanent ☐ Naturalized ☐ Alien Temporary

Job Data

Effective Date: 05 / 20 / 02

Action:

☐ Data Change
- ☐ FT to PT ☐ PRN to PT
- ☐ FT to PRN ☐ PRN to FT
- ☐ PT to FT ☐ PT to PRN
- ☐ Other _____

New Std Hours _____ Hrs / Wk

☐ Pay Rate Change
- ☐ Adjustment ☐ Min. Wage Increase
- ☐ Cost of Living ☐ Union Raise
- ☐ Merit ☐ Across the Board
- ☐ Other _____

New Rate $ _____

☐ Promotion ☐ Transfer ☐ Demotion
- Entity # _____
- Dept # _____
- Job Title: _____
- Job Code: _____

☒ LOA
- ☐ FMLA ☒ Workers Compensation
- ☐ Personal ☐ Military Service
- ☐ Education ☐ Other _____

Expected Return Date: ___ / ___ / ___

☐ Suspension

☐ Return From LOA/Suspension

☐ Union Affiliation Change

Union Code: _____

Effective Date of Membership ___ / ___ / ___

Corporate Use Only
- G/L Paytype: _____
- G/L Override: _____
- B.U. _____

Tax Data

Federal Tax Data
- Marital Status: ☐ Single ☐ Married
- Withholding Allow: _____
- Addl. Withholding: ☐ $ _____ ☐ % _____

State Tax Data
- Marital Status: ☐ Single ☐ Married
- Withholding Allow: _____
- Addl. Withholding: ☐ $ _____ ☐ % _____
- Resident State _____

Local Tax Data
- Resident: ☐ Yes ☐ No
- Locality: _____ County: _____
- Withholding Allow: _____
- Addl. Withholding: ☐ $ _____ ☐ % _____

Comments: _____

Signatures:

Manager: _____ Date: _____ H/R: S.R. K.R. Date: 5-22-02

Administrator: _____ Date: 5-24-02 Budget: _____ Date: _____

Next Level Mgr: _____ Date: _____

IHS 274

	RATING	COMMENTS
HUMAN RELATIONS		
1. A positive working relationship with patients/residents, visitors and facility staff is demonstrated.	1 (2) 3	
2. ~~Authority~~ is acknowledged and response to the direction of supervisors is appropriate.	1 (2) 3	
3. Time is spent with patients/residents rather than other personnel.	1 (2) 3	
4. Co-workers are readily assisted as needed.	1 (2) 3	
COST AWARENESS		
1. Supplies are used appropriately.	1 (2) 3	
2. Charge stickers (or charge system) are utilized appropriately.	1 (2) 3	
3. Minimal supplies are stored in the patient/resident room.	1 (2) 3	
4. Discharge medications are returned to the pharmacy in a timely manner.	1 2 (3)	- too often found w-stacks in the med rooms
5. Floor-stock medications are charged and restocked.	1 (2) 3	

PERFORMANCE INCIDENTS OR TRENDS:

well liked by residents, Consistent in care

Revised: 2/94
Reviewed:

IHS 178